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AUTHOR Sternlicht, Manny; Deutsch, Martin R.
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ABSTRACT

The trend toward normalization of the mentally retarded has brought a new dimension to the problem of their adjustment. Within the past several years, large numbers of the mentally retarded have been discharged into the community from residential facilities: the stress and anxiety they experience at being thrust into a strange and alien world often become overwhelming, and the individual may become psychologically immobilized. Crisis intervention has been used only marginally with the retarded in this and other situations. A crisis intervention model is proposed which targets four treatment areas: (1) emergency problems associated with behavior disorders; (2) incidents arising from emotional disturbance; (3) stress resulting from the transition between institution and community; and (4) crises in the community (particularly within families and foster families). Against the backdrop of de-institutionalization and community placement, the possibilities for the creative use of crisis intervention with the mentally retarded are manifold. (Author/CS)

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CRISIS INTERVENTION WITH THE MENTALLY RETARDED: THE NEW TREATMENT LOOK

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Manny Sternlicht & Martin R. Deutsch

Yeshiva University

New York City

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Though crisis intervention has come into high fashion within this decade as a psychological treatment strategy tailor-made for individuals in crisis situations that touch on everything from rape to flood disaster, there is only scant coverage of the subject in the existing literature on the mentally retarded. While crisis intervention has been undertaken with parents of the mentally retarded (e.g., Farber, Jenne, & Toigo, 1960; Giannini & Goodman, 1963), there is a dearth of such treatment efforts with the retarded themselves. In fact, a recent search of the literature succeeded in turning up only two papers describing crisis intervention efforts with the mentally retarded, both of them appearing within the last two years (Karan, 1977; Pierce, 1977).

This seeming lack of focused concern may be due in part to the fact that the phenomenon of crisis in the lives of the mentally retarded, particularly the institutionalized mentally retarded, has been relegated to the domain of behavior modification. The pre-existence of behavior modification as a treatment modality seems to have obviated the need for conceiving of disturbances in adjustment among the mentally retarded in crisis intervention terms.

This may, however, prove to be a shortcoming in our thinking for the reason that behavior modification and crisis intervention are in fact functionally distinguishable from each other as treatment entities.

Behavior modification is any planned and highly structured effort to modify disordered behavior toward a desired end over a period of time, via the systematic and sustained application of appropriate rewards and proper penalties. Crisis intervention is any immediate and on-the-spot attempt, by whatever means possible, to bring under control an emergency

situation which threatens the physical and/or psychological well-being of the individual in crisis or endangers others.

The former is a highly formalized, possibly long-term treatment undertaking; the latter is a momentary, stop-gap measure.

A medical analogy might serve to highlight the distinction. When an overweight individual involved in long-term diet control and physical exercise as part of a weight-loss program is suddenly discovered to be choking on a piece of diet-dinner meat that has lodged in the throat, diet and exercise cease to have any priorities in the presence of this life-threatening emergency. The Heimlich Maneuver, rather than Dr. Atkins' weight-loss strategy, becomes the order of the day.

So it is with behavior modification and crisis intervention. The former is what we would like to have happen; the latter is what we perforce must do.

An institutionalized retarded individual with a history of chronic head-banging, for example, may become a subject in a laboratory experiment to eliminate or reduce the target behavior through a planned program utilizing extinction and cultivation of incompatible behaviors as treatment techniques. Somewhere in the course of treatment, however, while in the living unit and not in the laboratory, the individual may suddenly and for unknown reasons become uncontrollably and dangerously violent. In such a situation, long-term planning must take a back seat to the emergency needs of the moment. What is called for is not planned psychological treatment but up-front emotional first aid. Behavior modification is the planned psychological treatment; crisis intervention is the emotional first aid.

Above and beyond this consideration, however, there is yet another reason for calling into play the concept of crisis intervention as a therapeutic tool for use in helping the mentally retarded to cope with their daily and often difficult life situations. The trend toward normalization of the mentally retarded has brought with it a whole new dimension to the problem of the adjustment of retarded individuals. Within the past several years, the mentally retarded, in significantly large numbers, have been discharged to the community from residential facilities which they had hitherto called their home for most if not all of their lives. The stress and anxiety which they experience at suddenly being thrust into a strange and alien world often become overwhelming. Psychological trauma, marked by what Goldstein (1939) has characterized as the catastrophic reaction, takes hold. The retarded individual becomes not just disjointed but immobilized as well.

This holds true not merely for the retarded individual who has already been placed in the community, but for the one who is about to be placed as well. One need only recall how disquieting and anxiety-provoking the process of leaving a place of long-term employment to take on a new job somewhere else might have been in our own lives to appreciate what an emotional ordeal the transition from institution to community must be for the mentally retarded. This is truly a time of crisis and one that calls for the availability of tools specially crafted for the management of crisis. This is a time for crisis intervention.

What, then, are the techniques of crisis intervention? With what types of problems have they been employed? How may they be adapted for use with the mentally retarded?

In its ever-expanding operation over the past decade, crisis intervention has run the emergency gamut: a woman who, in the aftermath of being assaulted and raped, has a great deal of difficulty sleeping, is fearful of being alone, and suffers morbid ruminations about the attack, all of which combine to make her feel that she is "losing control "; a man whose wife has left him for good and who, in a state of utter despair, is about to kill himself; a family that has lost its home in a flood and whose members, not knowing which way to turn, what to do, where to go, find themselves in a state of catastrophe and terror.

The rape victim, the abandoned husband, the bewildered and frightened family: these people and others with similar real-life emergency problems are the prime candidates for crisis intervention. It is a cluster of features in these situations - their critical nature, the immediacy and urgency of the real-life problems involved, and the apparent inability of the individuals to move toward a satisfactory resolution by themselves - that serves as their common denominator.

And in each case, it is a timely intervention at the moment of crisis that may alleviate the problem and prevent further, and perhaps more severe, consequences from developing.

Individuals who have typically been treated by crisis intervention fall into one of a number of problem-content categories: rape victims (e.g., Burgess & Holstrom, 1973); disaster victims (e.g. Tyhurst, 1958); individuals with marital problems (e.g., Richman & Davidoff, 1971); parents of premature infants and handicapped children (e.g., Kaplan & Mason, 1965; Park, 1977); drug users (e.g., Deeths, 1970); persons experiencing problems associated with aging (e.g., Oberleden, 1970); physically ill and pre-surgical patients (e.g., Bloch, 1967); the economically and socially

disadvantaged (e.g., Lerner, 1972); bereaved individuals (e.g., Baler & Golde, 1964; Madison, 1968); and suicidal individuals (e.g., Bagley, 1971; Farberow, 1968).

In addition, the treatment of soldiers with traumatic neuroses in World War II can be seen as the historical forerunner of contemporary crisis intervention (e.g. Grinker & Spiegel, 1944, 1945).

One can further classify these various crisis content categories, as Schwartz (1971) has done, by subsuming them under three broad headings: psychiatric emergencies, which include those cases where there is a full-blown manifestation of psychiatric illness in previously healthy individuals or acute exacerbations in chronically ill patients (e.g., suicidal individuals); accidental crises, which include those cases where there occurs an acute disorganization of affective, cognitive, and behavioral functioning precipitated by a stressful life experience (e.g., rape victims); and developmental crises, which include those cases where there is a period of acute disorganization of functioning transitional between one developmental phase and another (e.g., persons experiencing problems associated with aging).

We would add to these a fourth heading: situational crises, which include those cases where there is a life situation or condition that causes stress and gives rise to psychological disorganization (e.g., individuals with marital problems).

The stress disorders that are the targets of crisis intervention, as Butcher and Maudal (1976) point out, have several features in common. They are usually acute in nature, with a specifiable onset and a relatively brief duration. The number of alternative courses of action, whether adaptive or maladaptive, is limited. The possible courses of

action are usually identifiable and predictive of outcome. The observable symptoms of stress are usually transitory features of the individual's struggles to overcome the problem situation rather than signs of psychological disturbance. Characteristic psychological tasks posed by each situation are specifiable.

The transitory and circumstantial nature of the pathology associated with crisis states has been stressed by Lindemann (1944) and underscored by such other investigators as Caplan (1964) and Madison (1968).

The techniques of crisis intervention have been as thoroughly anchored in reality as the crises that they are trying to manage. These techniques have been very loosely organized and cover a wide range of procedures. Playing it by ear has prevailed as the unifying theme underlying all the techniques. In fact, it would be more to the point to speak of intervention principles rather than treatment techniques.

A set of such principles, enunciated by Caplan (1964) and summarized by Schwartz (1971), reflects the general view of practitioners in the field:

1. Help the individual to face the crisis and not to interpose denial and regression as psychological defenses.
2. Permit the individual to tackle the crisis in manageable doses by allowing "breathers" as it were and by providing medication where necessary.
3. Assist fact finding by helping the individual examine the problem in a reality-based frame of reference that keeps cognitive distortion to a minimum.
4. Avoid false reassurance concerning the outcome of the crisis itself but continue to express faith in the individual's ability to handle the crisis.

5. Discourage projection and the concomitant tendency to blame others for the crisis.
6. Help the individual to accept help.
7. Assist with everyday tasks that have to be attended to in the presence of the crisis in order to permit normal living to go forward in as orderly a way as possible.

All of the foregoing leads us to recognize that, beyond the reasons set forth earlier, there remains still another reason that crisis intervention has not found its way into the treatment armamentarium of those working with the mentally retarded. Crisis intervention has classically been applied in situations whose attempted resolution requires a good measure of verbal communication between the client and the counselor. The mentally retarded, whose deficiency in verbal comprehension and expression is the sine qua non of their being, are perforce limited in the extent to which they can benefit from verbally prompted insight into their own problems. For this reason, trying to dissuade a mentally retarded invidudual from committing suicide, for example, would require an extra measure of psychological deftness and innovation. This does not mean to say, however, that one cannot handle such problems with the mentally retarded. It simply requires some modification in the techniques that we use. Just as traditional psychotherapy has had to give way to a variety of novel and unorthodox techniques when used with the mentally retarded (Sternlicht, 1977), so crisis intervention must effect a change of direction in its handling of emergency situations which the retarded encounter in the course of their day-to-day living. The mere fact, therefore, that crisis intervention has not been widely employed with the mentally retarded should not be construed to mean that it cannot be employed.

We submit that there are a variety of ways in which crisis intervention can be put to valuable use with the mentally retarded. Our proposed crisis intervention model for the mentally retarded, which takes account of the transitional state in which the retarded find themselves in the presence of the trend toward normalization, sets its sights on four treatment target areas (c.f., Figure 1):

Insert Figure 1 about here

1. Emergency Problems Associated with Behavior Disorders.

In this category, intervention would center on such emergency problems as sudden physical outbursts, self-injurious episodes, assaultive and destructive incidents, and other violent acts by the mentally retarded that take place within the setting of a residential facility.

Upon receiving an emergency call via a telephone hot line, a member of the crisis intervention team would go to the site of the crisis to evaluate the problem and develop a course of action. That individual would remain on the scene until another team member relieves him or her or until the problem is solved. The team member would then return to the crisis center to prepare a report of the problem, the action taken, and suggestions for prevention of such crises in the future. Follow-up contacts would be made as the situation warrants.

2. Incidents Arising from Emotional Disturbance.

Crisis intervention would proceed the same as it does for behavior disorders, the focus in this case being on bizarre behaviors associated with phobias, delusions, hallucinations, and patterns of social withdrawal. Help would be available on an on-the-spot, round-the-clock basis via the telephone hot line.

3. Stresses Attendant Upon the Transition from Institution to Community.

Intervention efforts would concentrate on managing the manifold anxieties and fears of those mentally retarded individuals who are about to be placed in the community from a residential facility. At the same time, a crash effort would be directed toward the cultivation of those skills and abilities that the resident would need in order to make a successful community adjustment. Self-help skills, classroom preparedness, vocational readiness, interpersonal communication, and general social wherewithal would be among the areas of concentration. The effort would be tantamount to an intense and concentrated tutorial in the various phases of living geared to permitting the resident "to get his or her act together" before being thrust into a new, somewhat alien, and highly challenging way of life.

4. Crises in the Community.

The transition from institution to community is marked by a delicate period of adjustment, wherein the retarded must learn to live a new and normalized life within the context of a family setting, at the same time as family and friends must seek to make the individual's transition as smooth and unencumbered as possible.

Difficulties are bound to arise: the reaction of normal siblings to their new and perhaps idiosyncratic family member; the uncertain attitude of parents who, on the one hand, want their child to develop more rapidly than nature might prescribe and who, on the other hand, try to do everything to overprotect their offspring; the special medical and physical problems that are often part-and-parcel of the retarded individual's total condition.

Not only are problems such as these difficult for the retarded individual but they can place undue strain upon the family unit as a whole.

Such problems can take their toll of the mother and father, who may already be suffering from the prototypical clinical cluster of hostility, guilt, and anxiety that is so often found in the personality of the parents of retarded children.

For such parents, as well as for foster parents who are coming to experience their child for the very first time, psychological support and guidance are imperative if the parents are to be able to see their way clear to rearing their children in a wholesome and salubrious home atmosphere.

Parents who have encountered a special problem with their retarded child may, at any time in the course of the day, telephone a crisis counselor who will speak at length to the parents in an effort to help the family resolve or at least cope with the problem for the moment.

The value of a ready service of this kind is immeasurable for the reason that it lets the parents know that, no matter how seemingly insurmountable a problem might be at the moment, expert help is only a telephone call away.

More often than not, the problem is more imagined than real and telephone counseling lays it to rest.

In some cases, a problem encountered with a retarded individual at home may be serious enough to warrant direct intervention by a crisis counselor. An incident of sudden acting out, an unexplained excursion into a state of psychological depression or withdrawal, an accident or sudden illness are all problems which may call for remedial efforts right at the moment and directly on the spot.

Though we are admittedly covering ground in a largely virgin area,

it is reassuring to know that, as mentioned at the outset, at least two other practitioners working with the mentally retarded (Karan, 1977; Pierce, 1977) have described successful efforts that are in line with those which we have presently outlined.

The fact that the idea of crisis intervention with the mentally retarded has begun to emerge from several quarters suggests that the time may be ripe for its widespread implementation. It is our belief that the crisis intervention model which we have proposed for use with the mentally retarded will serve to fill a glaring gap that exists in the present state of the treatment art. Against the backdrop of de-institutionalization, community placement, and the entire trend toward normalization, the possibilities for the creative and productive use of crisis intervention with the mentally retarded are legion.

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Figure 1

4 - TIER CRISIS INTERVENTION MODEL